# CHAPTER VII

# RESIDENTS' RIGHTS AND RESPONSIBILITIES

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One of the conditions or standards for certification as a nursing home capable of providing care to Medicaid recipients is that residents' rights are assured. During utilization review visits, compliance investigations, or follow-up visits, the Department of Medical Assistance Services (DMAS) staff will evaluate whether the nursing home recognizes and adheres to regulations and policies concerning these rights. Rights are applicable to the resident and his or her legal representative.

## RESIDENTS' RIGHTS - NURSING HOMES

Provisions in recent federal statutes revised and expanded the requirements for nursing facility residents' rights. These requirements apply only to nursing homes and do not apply to facilities for the mentally retarded. Nursing homes must protect and promote the rights of each resident, including each of the following rights:

**Advance Directives**: All nursing homes participating in the Medicare and Medicaid programs must provide adult residents with information regarding an individual's right to make medical care decisions. This includes the right to accept or refuse medical treatment and the right to formulate advance directives.

The term "advance directive" means a written instruction, such as a living will or durable power of attorney for health care, recognized under state law and relating to the provision of such care when the individual is incapacitated. The law does not prohibit any health care provider (or any agent of such provider) from refusing, as a matter of conscience, to implement an advance directive. Further, the law does not require individuals to execute an advance directive.

Under the law, nursing homes must:

- Provide all adult individuals with written information about their rights under state law to make health care decisions, including the right to accept or refuse treatment and the right to execute advance directives as well as the provider's written policies respecting the implementation of such rights;
- Inform residents about the facility's policy on implementing advance directives;
- Document in the resident's medical record whether he or she has signed an advance directive;
- Not discriminate against an individual based on whether he or she has executed an advance directive; and
- Provide staff and community education on advance directives.

Nursing homes must provide written information to adult residents at the time of each individual's admission to the facility.

**Exercise of Rights**: The residents have a right to a dignified existence, self-determination, and communication with access to persons and services inside and outside the nursing home. A nursing home must protect and promote the rights of each resident, including each of the following:

- The resident has the right to exercise his or her rights as a citizen of the nursing home and as a citizen of the United States;
- The resident has the right to be free of interference, coercion, discrimination, or reprisal from the nursing home in exercising his or her rights;
- In the case of a resident adjudged incompetent under the laws of a state by a court of competent jurisdiction, the rights of the resident are exercised by the person appointed under state law to act on the resident's behalf; and
- In the case of a resident who has not been adjudged incompetent under the laws of a state by a court of competent jurisdiction, any legal surrogate designated in accordance with state law may exercise the resident's rights to the extent provided by state law.

**Notice of Rights and Services**: The nursing home must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the nursing home. The nursing home must also provide the resident with the notice (if any) of the state developed under § 1919(e)(6) of Title XIX of the Social Security Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing.

The resident or his or her legal representative has the right, upon an oral or written request, to access all records pertaining to himself or herself (including current clinical records) within 24 hours (excluding weekends and holidays) and, after receipt of his or her records for inspection, to purchase at a cost not to exceed the community standard photocopies of the records or any portions of them upon request and two working days' advance notice to the nursing home.

The resident has the right to be fully informed in a language that he or she can understand of his or her total health status, including but not limited to, his or her medical condition. The resident has the right to refuse treatment and to refuse to participate in experimental research.

The nursing home must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing home or when the resident becomes eligible for Medicaid, of the items and services that are included in nursing home services under the *State Plan for Medical Assistance* and for which the resident may not be charged, as well as of those other items and services that the facility offers and for which the resident may

be charged (and the amount of those charges). In addition, the nursing home must inform each resident when changes are made to the items and services specified above. Note that the Medicaid reimbursement formula is designed to meet the cost of resident care, support, and maintenance, including personal laundry and admission kits. The resident's personal care allowance is to be used only for the resident's personal needs, such as cosmetics, magazines, candy, and travel funds to visit family.

The nursing home must inform each resident, before or at the time of admission and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate.

The nursing home must furnish a written description of legal rights which includes: 1) a description of the manner of protecting personal funds; 2) a description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels; 3) a posting of names, addresses, and telephone numbers of all pertinent state client advocacy groups such as the state survey and certification agency, the state licensure office, the State Ombudsman Program, the protection and advocacy network, and the Medicaid Fraud Control Unit; and 4) a statement that the resident may file a complaint with the state survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility.

The nursing home must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care.

The nursing home must prominently display this written information in the facility and must provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits and how to receive refunds for previous payments covered by such benefits.

A nursing home must immediately inform the resident, consult with the resident's physician, and if known, notify the resident's legal representative or interested family member when there is: 1) an accident involving the resident which results in injury and has the potential for requiring physician intervention; 2) a significant change in the resident's physical, mental, or psychosocial status (e.g., a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); 3) a need to alter treatment significantly (e.g., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or 4) a decision to transfer or discharge the resident from the nursing home.

The nursing home must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment or a change in resident rights under federal or state law or regulations.

The nursing home must record and periodically update the address and phone number of the resident's legal representative or interested family member.

**Protection of Resident Funds**: The resident has the right to manage his or her financial affairs, and the nursing home may not require residents to deposit their personal funds with the facility. Upon written authorization of the resident, the nursing home must hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility. (See "Personal Care Allowance [Patient Fund Account]" and "Patient Fund Account System Requirements" for facility requirements with regard to management of and accounting for patient funds.) The nursing home must deposit any resident's personal funds in excess of $50 in an interest-bearing account (or accounts) that: (1) is separate from any of the facility's operating accounts, and (2) credits all interest earned on resident's funds to that account. In pooled accounts, there must be a separate accounting for each resident's share. The nursing home must maintain a resident's personal funds that do not exceed $50 in a non-interest-bearing account, interest-bearing account, or petty cash fund.

The nursing home must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the nursing home on the resident's behalf. The system must preclude any commingling of resident funds with nursing home funds or with the funds of any person other than another resident. The individual financial record must be available through quarterly statements and on request to the resident or his or her legal representative.

The nursing home must notify each resident who receives Medicaid benefits: 1) when the amount in the resident's account reaches $200 less than the SSI resource limit for one person, and 2) if the amount in the account, in addition to the value of the resident's other nonexempt resources, reaches the SSI resource limit for one person, the resident may lose eligibility for Medicaid or SSI.

Upon the death of a resident with a personal fund deposited with the nursing home, the nursing home must convey the resident's funds, and a final accounting of those funds, to the individual or probate jurisdiction administering the resident's estate within 30 days.

The nursing home must purchase a surety bond, or otherwise provide assurance satisfactory to the Secretary of Health and Human Services, to assure the security of all personal funds of residents deposited with the facility. The nursing home may not impose a charge against the personal funds of a resident for any item or service for which payment is made under Medicaid or Medicare.

**Free Choice**: The resident has the right to: 1) choose a personal attending physician, 2) be fully informed in advance about care and treatment and of any changes in that care or treatment that may affect the resident's well-being, and 3) unless adjudged incompetent or otherwise found to be incapacitated under the laws of the state, participate in planning care and treatment or changes in care and treatment.

**Privacy and Confidentiality**: The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy rights extend to

accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups. This does not require a nursing home to provide a private room for each resident.

The resident may approve or refuse the release of personal or clinical records to any individual outside the nursing home, except when the resident is transferred to another health care institution or a record release is required by law.

**Grievances**: A resident has the right to voice grievances without discrimination or reprisal. Such grievances include those with respect to treatment which has been furnished as well as that which has not been furnished. The resident has the right to prompt efforts by the nursing home to resolve grievances the resident may have, including those with respect to the behavior of other residents.

**Examination of Survey Results**: The resident has the right to examine the results of the most recent survey conducted by federal or state surveyors and any plan of correction in effect with respect to the facility. The resident has the right to receive information from agencies acting as client advocates and be afforded the opportunity to contact those agencies. The nursing home must make the results available for examination in a place readily accessible to residents and must post a notice of their availability.

**Work**: The resident has the right to: 1) refuse to perform services for the nursing home or 2) perform services for the nursing home, if he or she chooses, when the nursing home has documented the need or desire for work in the plan of care. The plan must specify the nature of the services performed and whether the services are voluntary or paid. Compensation for paid services must be at or above prevailing rates, and the resident must agree to the work arrangement described in the plan of care.

**Mail:** The resident has the right to privacy in written communications, including the right to send and promptly receive mail that is unopened and have access to stationery, postage, and writing implements at his or her own expense.

**Access and Visitation Rights**: The resident has the right to access to, and a nursing home must provide immediate access to residents by, the following:

- Any representative of the U.S. Department of Health and Human Services, any representative of the state, his or her individual physician, the State Long-Term Care Ombudsman, the agency responsible for the protection and advocacy system for developmentally disabled individuals, and the agency responsible for the protection and advocacy system for mentally ill individuals;

- Subject to the resident's right to deny or withdraw consent at any time, immediate family or other relatives of the resident; and

- Subject to reasonable restrictions and the resident's right to deny or withdraw consent at any time, others who are visiting with the consent of the resident.

The facility must also provide reasonable access to any resident by any entity or individual that provides health, social, legal, or other services to the resident, subject to the resident's

right to deny or withdraw consent at any time. The nursing home must allow representatives of the State Ombudsman Program to examine a resident's clinical records, with the permission of the resident (or the resident's legal representative) and consistent with state law.

**Telephone**: The resident has the right to have reasonable access to the private use of a telephone where calls can be made without being overheard.

**Personal Property**: The resident has the right to retain and use personal possessions, including some furnishings and appropriate clothing, as space permits, unless to do so would infringe upon the rights, health, or safety of other residents.

**Married Couples**: The resident has the right to share a room with his or her spouse when married residents live in the same facility and both spouses consent to the arrangement, unless medically contraindicated as documented by the resident's physician in the resident's medical record.

**Self-Administration of Drugs**: An individual resident may self-administer drugs if the interdisciplinary team has determined that this practice is safe.

**Refusal of Certain Transfers**: A resident has the right to refuse a transfer to another room within the institution: (1) if the purpose of the transfer is to relocate a resident of a skilled nursing home from the distinct part of the institution that is a skilled nursing home to a part of the institution that is not a skilled nursing home, or, (2) if a resident of a nursing home from the distinct part of the institution that is a nursing home to a distinct part of the institution that is a skilled nursing home. Exercising this right to refuse transfer does not affect the resident's eligibility or entitlement to Medicare or Medicaid benefits.

**Transfer and Discharge**: Transfer and discharge includes the movement of a resident to a bed outside of the certified nursing home whether or not that bed is in the same physical plant. Transfer and discharge does not refer to the movement of a resident to a bed within the same certified nursing home. The nursing home must permit each resident to remain in the nursing home and not transfer or discharge unless:

a. The transfer or discharge is necessary for the resident's welfare, and the resident's needs cannot be met in the nursing home;

b. The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the nursing home;

c. The safety of individuals in the nursing home is endangered;

d. The health of individuals in the nursing home would otherwise be endangered;

e. The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the nursing home. For a resident who becomes eligible for Medicaid after admission to a nursing home,

the nursing home may charge a resident only allowable charges under Medicaid; or

f. The facility ceases to operate.

When the nursing home transfers or discharges a resident under any of the circumstances described in (a) through (e) above, the transfer or discharge must be documented in the resident's clinical record. The documentation must be made by the resident's physician when transfer or discharge is necessary because of the reasons described in (a) or (b), and by a physician when the transfer or discharge is necessary due to the reason stated in (d).

Before a nursing home transfers or discharges a resident, the nursing home must 1) notify the resident and, if known, a family member or legal representative of the resident of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand; 2) record the reasons in the resident's clinical record; and 3) include in the notice the items described in (a) through (f) above. The notification must be made by the nursing home at least 30 days before the resident is transferred or discharged. Notice may be made as soon as is practicable before discharge or transfer when:

- The safety of the individuals in the nursing home would be endangered;
- The health of individuals in the nursing home would be endangered;
- The resident's health improves sufficiently to allow a more immediate transfer or discharge;
- An immediate transfer or discharge is required by the resident's urgent medical needs; or
- A resident has not resided in the nursing home for 30 days.

The written notice must include a) the reason for the transfer or discharge, b) the effective date of the transfer or discharge, c) the location to which the resident is transferred or discharged; and d) a statement that the resident has the right to appeal the action to the state. The notice must also include the name, address, and telephone number of the State Long-Term Care Ombudsman. For nursing home residents with developmental disabilities or mental illness, the notice must include the mailing address and telephone number of the Department for Rights of Virginians with Disabilities.

A nursing home must provide sufficient preparation and orientation to residents to ensure a safe and orderly transfer or discharge from the nursing home. In addition, the nursing home must assist the resident and his or her family in locating and coordinating the services needed for a smooth transition. Residents and their families and legal representatives have the right to choose their own service providers.

In addition to the federal requirements above regarding transfer and discharge, nursing home should also note the requirements of subsection B of §32.1-138 of the Code of Virginia:

- All established policies and procedures regarding the rights and responsibilities

> of patients shall be printed in at least twelve-point type and posted conspicuously in a public place in all nursing home facilities required to be licensed under the provisions of Article 1 (§ 32.1-123 et seq.) of this chapter. These policies and procedures shall include the name and telephone number of the complaint coordinator in the Division of Licensure and Certification of the Virginia Department of Health as well as the toll-free number for the Virginia Long-Term Care Ombudsman Program and any substate ombudsman program serving the area. Copies of such policies and procedures shall be given to patients upon admittance to the facility and made available to patients currently in residence, to any guardians, next of kin, or sponsoring agency or agencies, and to the public.

Per § 32.1-138.1 of the Code of Virginia, a nursing home may discharge or transfer a patient, including transfer within the nursing home, only: (1) if appropriate to meet that patient's documented medical needs; (2) if appropriate to safeguard that patient or one or more other patients from physical or emotional injury; or (3) On account of nonpayment for his or her stay except as prohibited by Title XVIII or XIX of the Social Security Act and the Virginia *State Plan for Medical Assistance Services*.

Except in an emergency involving the resident's health or well-being, no resident shall be transferred, including transfer within the nursing home, or discharged without prior consultation with the patient, the patient's family or responsible party, and the patient's attending physician. If the attending physician is unavailable, the nursing home's medical director, in conjunction with the nursing director, social worker, or another health professional, must be consulted. Reasonable advance written notice must be given in the following manner. For a voluntary transfer or discharge, notice must be reasonable under the circumstances. For an involuntary transfer, including a transfer within the nursing home, reasonable advance notice must be given to the patient at least five days prior to the transfer.

In the case of an involuntary transfer or discharge, the attending physician of the patient or the medical director of the nursing home shall make a written notation in the patient's record approving the transfer or discharge after consideration of the effects of the transfer (including a transfer within the nursing home) or discharge, appropriate actions to minimize the effects of the transfer or discharge, and the care and kind of service the patient needs upon transfer or discharge.

**Notice of Bed-Hold Policy and Readmission**: Before a nursing home transfers a resident to a hospital or allows a resident to go on therapeutic leave, the nursing home must provide written information to the resident and a family member or legal representative that specifies: 1) the duration of the bed-hold policy under the *State Plan for Medical Assistance*, if any, during which the resident is permitted to return and resume residence in the facility; and 2) the facility's policies regarding bed-hold periods following hospitalization or therapeutic leave, permitting a resident to return.
At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing home must provide to the resident and a family member or legal representative written notice which specifies the duration of the bed-hold policy. A nursing home must establish and follow a written policy under which a resident, whose hospitalization or therapeutic leave

exceeds the bed-hold period under the *State Plan for Medical Assistance*, is readmitted to the nursing home immediately upon the first availability of a bed in a semi-private room if the resident: 1) requires the services provided by the nursing home, and 2) is eligible for Medicaid nursing home services.

**Equal Access to Quality Care**: A nursing home must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the *State Plan for Medical Assistance* for all individuals regardless of the source of payment. The nursing home may charge any amount for services furnished to non-Medicaid residents consistent with the required notice describing the charges. The state is not required to offer additional services on behalf of a resident other than services provided in the *State Plan for Medical Assistance*.

**Admissions Policy**: The nursing home must not require residents or potential residents to waive their rights to Medicare or Medicaid or require oral or written assurance that residents or potential residents are not eligible for, or will not apply for, Medicare or Medicaid benefits.

The nursing home must not require a third-party guarantee of payment to the nursing home as a condition of admission, expedited admission, or continued stay in the nursing home. However, the nursing home may require an individual who has legal access to a resident's income or resources available to pay for nursing home care to sign a contract, without incurring personal financial liability, to provide nursing home payment from the resident's income or resources.

In the case of a person eligible for Medicaid, a nursing home must not charge, solicit, accept, or receive, in addition to any amount otherwise required to be paid under the *State Plan for Medical Assistance*, any gift, money, donation, or other consideration as a precondition of admission, expedited admission, or continued stay in the nursing home. However, a nursing home may charge a resident who is eligible for Medicaid for items and services that the resident has requested and received and that are not specified in the State Plan for Medical Assistance as included in the term "nursing facility services" so long as the nursing home gives proper notice of the availability and cost of these services to residents and does not condition the resident's admission or continued stay on the request for and receipt of such additional services.

A nursing home may solicit, accept, or receive a charitable, religious, or philanthropic contribution from an organization or from a person unrelated to a Medicaid-eligible resident or potential resident, but only to the extent that the contribution is not a condition of admission, expedited admission, or continued stay in the nursing home for a Medicaid-eligible resident.

**Restraints**: The resident has the right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience and not required to treat the resident's medical symptoms. Restraints may only be imposed to ensure the physical safety of the resident or other residents and only upon the written order of a physician that specifies the duration and circumstances under which the restraints are to be used (except in emergency situations until such an order could reasonably be obtained). When used, there must be

definitive documentation in the resident's medical record to include the type of and reason for restraint, duration of use, and checks for positioning and issues of safety.

**Abuse and Staff Treatment of Residents**: The resident has the right to be free from verbal, sexual, physical or mental abuse, corporal punishment, and involuntary seclusion. The nursing home must develop and implement written policies and procedures that prohibit mistreatment, neglect, or abuse of residents and misappropriation of resident property. The nursing home must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion. The nursing home must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law or have had a finding entered into the state nurse aide registry concerning abuse, neglect, mistreatment of residents, or misappropriation of their property.

The nursing home must also report any knowledge it has of actions by a court of law against an employee which would indicate unfitness for service as a nurse aide or other nursing home staff to the state nurse aide registry or licensing authorities. The nursing home must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source, and misappropriation of resident property are reported immediately to the administrator of the nursing home or to other officials in accordance with state law through established procedures (including to the Department of Health, Division of Licensure and Certification).

In addition, the nursing home must have evidence that all alleged violations are thoroughly investigated and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his or her designated representative and to other officials in accordance with state law (including to the Department of Health, Division of Licensure and Certification) within five (5) working days of the incident. If the alleged violation is verified, appropriate corrective action must be taken.

**Dignity**: A nursing home must care for its residents in a manner and in an environment that promotes maintenance or enhancement of each resident's quality of life. The nursing home must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.

**Self-Determination and Participation**: The resident has the right to: 1) choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; 2) interact with members of the community both inside and outside the nursing home; and 3) make choices about aspects of his or her life in the nursing home that are significant to the resident.

**Participation in Resident and Family Groups**: A resident has the right to organize and participate in resident groups in the nursing home. A resident's family has the right to meet in the nursing home with the families of other residents in the nursing home. The nursing home must provide a resident or family group, if one exists, with private space. Staff or visitors may attend meetings at the group's invitation. The nursing home must provide a designated staff person responsibility for providing assistance and responding to written requests that result from group meetings. When such a resident or family group exists, the

nursing home must listen to the views and act upon the grievances and recommendations of residents and families concerning proposed policy and operational decisions affecting resident care and life in the facility.

**Activities**: The nursing home must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident.

**Social Services**: The nursing home must provide medically related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.

**Accommodation of Needs**: The resident has the right to reside and receive services with reasonable accommodation of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered, and receive notice before the resident's room or roommate is changed.

**Environment**: The nursing home must provide a safe, clean, comfortable, and home-like environment, allowing the resident to use his or her personal belongings to the extent possible. The nursing home must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; clean bed and bath linens that are in good condition; private closet space in each resident room; adequate and comfortable lighting levels in all areas; comfortable and safe temperature levels; and maintenance of comfortable sound levels.

A Federal Bill of Rights for Nursing Facility Residents is included in "Exhibits" at the end of this chapter and is a compilation of nursing facility resident rights as found in the Omnibus Budget Reconciliation Act of 1987. While this may be used to inform nursing home residents of their rights, nursing home must update any existing nursing home policies as necessary in order to be in compliance with the law.

## RESIDENTS' RIGHTS - FACILITIES FOR THE MENTALLY RETARDED

The nursing home must ensure the rights of all residents. Specifically, for the mentally retarded, the nursing home must:

- Inform each resident, parent (if the resident is a minor), or legal guardian, of the resident's rights and the rules of the facility;
- Inform each resident, parent (if the resident is a minor), or legal guardian, of the resident's medical condition, developmental and behavioral status, attendant risks of treatment, and right to refuse treatment;
- Allow and encourage individual residents to exercise their rights as residents of the facility, and as citizens of the United States, including the right to file complaints, and the right to due process;
- Allow individual residents to manage their financial affairs and teach them to do so to the extent of their capabilities;

- Ensure that residents are not subjected to physical, verbal, sexual, or psychological abuse or punishment;
- Ensure that residents are free from unnecessary drugs and physical restraints and are provided active treatment to reduce dependency on drugs and physical restraints;
- Provide each resident with the opportunity for personal privacy and ensure privacy during treatment and the care of personal needs;
- Ensure that residents are not compelled to perform services for the facility and ensure that residents who do work for the facility are compensated for their efforts at prevailing wages and commensurate with their abilities;
- Ensure residents the opportunity to communicate, associate and meet privately with individuals of their choice and to send and receive unopened mail;
- Ensure that residents have access to telephones with privacy for incoming and outgoing local and long distance calls, except as contraindicated by factors identified within their individual program plans;
- Ensure residents the opportunity to participate in social, religious, and community group activities;
- Ensure that residents have the right to retain and use appropriate personal possessions and clothing and ensure that each resident is dressed in his or her own clothing each day; and
- Permit a husband and wife who both reside in the facility to share a room.

**PERSONAL NEEDS ALLOWANCE (RESIDENT FUND ACCOUNT)**

Every Medicaid recipient residing in a nursing home is entitled to a personal care allowance of $30 per month. An exception to this rule occurs when Medicaid applicants or recipients in a nursing home or a facility for the mentally retarded are regularly involved in vocational activity which is part of a planned habilitation program carried out in a therapeutic work program, such as a sheltered workshop, prevocational training, or vocational training. These individuals will be allowed to retain $75 of earnings each month and 50 percent of any additional earnings up to a maximum of $190 per month. Another exception applies to certain veterans and surviving spouses. These individuals will be allowed to retain $90 each month.

The Medicaid reimbursement formula is designed to meet the cost of resident care, support, and maintenance. A nursing home may not impose a charge against the personal funds of a resident for any item or service for which payment is made under Medicaid or Medicare (except for applicable deductible and coinsurance amounts). The nursing home may charge the resident for requested services that are more expensive than or in excess of

covered services. During the course of a covered stay, facilities may not charge a resident for the following categories of items and services:

- Nursing services as required by 42 CFR § 483.30;
- Dietary services as required by 42 CFR § 483.35;
- An activities program as required by 42 CFR § 483.15(f);
- Medically related social services as required by 42 CFR § 483.15(g);
- Room and bed maintenance services;
- Routine personal hygiene items and services as required to meet the needs of residents, including, but not limited to, hair hygiene supplies, brush, bath soap, disinfecting soaps or specialized cleansing agents when indicated to treat special skin problems or to fight infection, razor, shaving cream, toothbrush, toothpaste, denture adhesive, denture cleaner, dental floss, moisturizing lotion, tissues, cotton balls, cotton swabs, deodorant, incontinence care and supplies, towels, washcloths, hospital gowns, over-the-counter drugs, hair and nail hygiene services, bathing, and basic personal laundry; and

  While nursing homes are not required to provide specific brands of items, they must provide products that are sufficient to meet the needs of residents (e.g., allergies might create the need for additional brands of soap). If a resident prefers and requests a certain brand, a nursing home may charge the resident the difference between the cost of the brand requested and the brand generally provided.

Listed below are general categories and examples of items and services that the nursing home may charge to residents' funds **if they are requested** in writing by a resident, if the facility informs the resident that there will be a charge and if payment is not made by Medicaid or Medicare:

- Telephone, television, or radio for personal use;
- Personal comfort items, including smoking materials, notions and novelties, and confections;
- Cosmetic and grooming items and services in excess of those for which payment is made under Medicaid or Medicare;
- Personal clothing; personal reading matter; gifts purchased on behalf of the resident; and flowers and plants;
- Social events and entertainment offered outside the scope of the activities program;

- Non-covered special care services such as privately hired nurses or aides;
- Private room, except when therapeutically required (for example, isolation for infection control);
- Specially prepared or alternative food requested instead of the food generally prepared by the facility;
- Premiums on life insurance or burial policies on the recipient and from which the recipient's expenses (e.g., for burial) can be expected to be paid; and
- Travel funds for the recipient to visit home or family.

If all current needs are being met, the funds may be conserved in a trust fund for the transitional needs of the recipient upon release or transfer from the nursing home. The nursing home must not charge a resident (or his or her representative) for any item or service as a condition of admission or continued stay. The nursing home must not require a resident (or his or her representative) to request any item or service as a condition of admission or continued stay. The nursing home must inform the resident (or his or her representative) requesting an item or service for which a charge will be made that there will be a charge for the item or service and what the charge will be.

**RESIDENT FUND ACCOUNT SYSTEM REQUIREMENTS**

Each nursing home which accepts deposits to and maintains the Resident Fund Account must provide for the protection and proper expenditure of these funds on behalf of the residents. The Office of Health Facilities Regulation of the Department of Health will review each nursing home's system as a condition of participation. The system requirements are:

**I. Written Statement**

The nursing home must provide each resident and resident representative with a written statement at the time of admission that:

A. Distinguishes between those services included in the nursing home's basic rate and services charged to the resident's personal funds;

B. States that a deposit of residents' funds at the nursing home is voluntary and for the convenience of the resident;

C. Describes the resident's right to:

1. Manage his or her personal funds;

2. Apply to the Social Security Administration to have a representative payee designated;

3. Designate in writing another person to manage the personal funds; and

4. The nursing home's obligation upon deposit of the personal funds by the resident to safeguard and account for such funds;

D. States that any charge relating to the nursing home managing the personal funds is included in the nursing home's basic rate; and

E. States that if the resident becomes incapable of managing his or her personal funds and does not have a designated written representative, the facility is required to arrange for the management of the personal funds.

## II. Record Keeping

The nursing home must keep records which include at least the following:

A. Establishment of a Ledger Card for each resident whose Resident Fund Account is maintained which includes:

1. The resident's name;

2. Identification of the resident's representative;

3. The admission date, and if applicable, discharge date; the Resident Fund Account closing date; and final disposition of account balance;

4. The date and amount of all deposits and withdrawals and the current balance; and

5. The date and amount of all interest earned and credited to the resident's account.

B. Receipts indicating the purpose of withdrawal(s) when a resident is not capable of handling his or her own funds, the nursing home should keep pre-numbered voucher slips indicating:

1. Item(s) purchased, and cash register or sales slip(s) and

2. Two signatures, such as the facility Administrator, Director of Nurses, Social Services Director, or family member being reimbursed for the purchases.

C. A quarterly written statement issued to the resident or designated representative must include the following:

1. The balance at the beginning of the period;

2. The total deposits and withdrawals;

3. The interest earned;

4. The balance at the end of the period; and

5. The identification number and location of personal fund accounts;

D. Commingling the Resident Fund Accounts with the nursing home account is prohibited by federal regulations and the Code of Virginia. The nursing home must immediately deposit any funds received from or on behalf of a resident in the Resident Personal Fund trust account. Transfers of any patient pay amounts due to the nursing home must be made from the Resident Personal Funds trust account to the facility account. A nursing home Control Account for patients must be established. Total receipts and disbursements for all patient funds should be posted to this account. The balance in this account, as well as the balance of the offsetting liability account, must be shown on the provider's financial statements.

In MR facilities, federal statutes preclude any commingling of client funds with facility funds or with the funds of any person other than another client.

The client's financial record must be available upon request to the client, parents (if the client is a minor), or legal guardian.

On a monthly basis, the individual patient ledger cards are to be balanced to this control account which is in turn reconciled to the custodian bank account.

## IV. Interest Bearing Accounts

Upon written authorization of a resident, the nursing home must hold, safeguard, manage, and account for the resident's personal funds which are deposited with the nursing home. The nursing home must deposit any resident's personal funds in excess of $50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and credit all interest earned to the resident. The account may be individual or pooled. If a pooled account is used, proper records must be maintained so that each patient's funds can be individually identified. Records must indicate that the nursing home does not have an ownership interest in the funds and the account must be insured under federal or state law. The nursing home must have a written policy stating how interest earned on any pooled interest bearing account is prorated to each resident whose funds are in the account. Resident account balances must be reconciled monthly and interest must be prorated

monthly. The facility must maintain a resident's personal funds that do not exceed $50 in an interest-bearing account, a non-interest bearing account or a petty cash fund. The nursing home must notify each resident who receives Medicaid benefits when the amount in the resident's account(s) reaches $200 less than the SSI resource limit for one person. The facility must also inform the resident that if the amount in the account in addition to the value of the resident's other non-exempt resources reaches the SSI resource limit for one person, the resident may lose eligibility for Medicaid or SSI.

## V. Access to Funds Held in the Facility

A. Daily Access

The resident must have access to funds daily, at least two (2) hours during normal business hours, and for some reasonable time on Saturdays and Sundays.

B. Resident Discharge

The nursing home must, upon request by the resident or the person designated in writing by the resident, return within five business days the balance of the resident's personal funds that the facility has received.

C. Change in Ownership

The nursing home must provide a new owner with a written accounting of all patient funds being transferred and obtain a written receipt for those funds.

The nursing home must give each resident or designated representative a written accounting of any personal funds held by the nursing home before any transfer of ownership occurs.

D. Death of Resident

1. **Resident Account Does Not Exceed Medicaid Resource Level**

The nursing home must provide the executor or administrator of a resident's estate with a written accounting of the resident's personal funds within 10 business days of a resident's death. If no such executor or administrator exists, refunds from accounts of deceased residents should be made in the following order:

a. To the establishment that conducts the funeral arrangements for burial expenses (if still unpaid at the time of refund);

b. To the designated responsible party or family member (see Section I); and

c. Any remaining balance will be reported to the circuit court in the city or county in which the resident resided.

d. Division of Unclaimed Property at the following address:

Commonwealth of Virginia
Department of the Treasury
Division of Unclaimed Property
P.O. Box 2478
Richmond, Virginia 23218

2. **Resident Account Exceeds the Medicaid Resource Level**

The facility should notify the Department of Social Services (DSS) any time the resident's personal funds exceed the Medicaid resource level.

The nursing home must provide DMAS with a written notice of the full amount of funds in the resident's personal funds account on the date of death. This notice is to be provided within 10 days after the date of the resident's death to:

Benefits Control Manager
Division of Program Operations
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

Upon the death of a resident with a personal fund deposited with the facility, the facility must convey within 30 days the resident's funds and a final accounting of those funds to the individual administering the resident's estate or to the probate jurisdiction administering the resident's estate. See 42 CFR § 483.10 (c)(6)

## VI. Resident Incapable of Managing Funds

If a resident is incapable of managing personal funds and has no representative, the nursing home must notify the Adult Protective Services Unit within the local department of social services.

## VII. Audit

A periodic examination of the nursing home's handling of resident funds will be conducted by auditors from the Fiscal Division of DMAS. If there are any questions, contact the provider's designated Virginia Medical Assistance Program representative for assistance.

## PATIENT PAY AND USE OF DMAS-122

The Patient Information Form (DMAS-122) establishes the financial responsibility (patient pay) for Medicaid recipients toward their cost of care in a nursing home. The DMAS-122, shown in Chapter VI, is completed by the responsible local DSS and submitted to the nursing home of residence upon admission or determination of eligibility and when changes in the recipient's income or status occur. This document will clearly identify a patient's Medicaid eligibility status and will indicate if a patient has other health insurance coverage available. A recipient's financial responsibility toward his or her cost of care will be identified as the patient pay amount. The effective date, month, and year for the patient pay amount is shown on the form. Multiple spaces are included on the form to allow for changes in the patient pay amount (i.e., the admission month patient pay amount and the regular patient pay amount effective the month(s) following the admission month). The DMAS-122 must also be initiated by the nursing home to show the admission date, to request Medicaid eligibility status, the Medicaid recipient I.D., and the patient pay amount, and to notify the local DSS of changes in the patient's circumstances, discharge, or death. The nursing home must submit a DMAS-122 to the responsible local DSS whenever the nursing home has acknowledged that a recipient's income has changed (e.g., an increase in Social Security or Railroad Retirement).

Only the cost of medically necessary, resident-specific, customized, or non-covered medical services, supplies, and equipment may be deducted from patient pay. General exclusions of non-covered medical services can be found in Chapter I. DMAS cannot perform a DMAS-122 adjustment if the resident does not have a copay (patient pay amount).

### Patient Pay on Billing Invoice

The DMAS-122 is an audit document. It is the nursing home's responsibility to have a current and complete DMAS-122 on file for each resident before billing can occur. The nursing home must credit the Medical Assistance Program monthly with the full amount of the resident's financial obligation, as listed on the DMAS-122, on line 21 of the DMA-215 (Nursing Home Invoice). The facility must also enter the date of availability of the financial participation, per DMA-122, on line 22 of the DMA-215. The patient pay must be applied to the cost each month before Medicaid responsibility begins. The facility must apply full patient pay or that which covers charges on the first half of split billings. (See Chapter V for billing instructions.)

### Patient Pay Exceeds Cost of Care

When a resident is discharged or dies early in the month and his or her patient pay is more

than sufficient to cover the cost of care, bill the Medicaid Program. Even though no payment will be made by DMAS, it is necessary to record the correct number of Medicaid days in the system. Apply the patient pay at the Medicaid per diem rate of the particular facility. Unused patient pay should be returned to the resident or family.

Change in Recipient's Resources

The local DSS is responsible for keeping the DMAS-122 current due to changes in the recipient's resources. Should the nursing home have knowledge of income or other circumstances different from that indicated by the DMAS-122, the facility must notify the local DSS. Upon receipt of the corrected DMAS-122, any discrepancies between the Patient Information Form and previously paid claims should be corrected by submission of the UB-92 HCFA-1450 as an adjustment invoice by the nursing facility. (See Chapter V for instructions.)

If a resident requires medical services not covered by Medicaid (e.g., dental), the responsible local social services department may prepare a DMAS-122 (for a specified period of time) that allows for funds normally available for nursing care to be available to pay for the non-covered medical services. Such medical services must not be covered in any form by Medicaid or be subject to third-party payment. The nursing home must submit the request for DMAS-122 adjustment to the local DSS. The DMAS-122 adjustment request must also include the recipient identification, Medicaid number, physician orders for the item or service not covered, medical justification for the item or service being requested, item or service description, and cost information. When Medicare or any other insurance denies a claim, a copy of the denial letter should be included with a DMAS-122 adjustment.

Certain medical equipment items, such as wheelchairs, recliners, geriatric chairs, special mattresses, and medical equipment that residents need are supplied by the nursing facility to the residents at no extra cost to the resident. This equipment is covered by Medicaid as part of Medicaid's reimbursement to the nursing home for the resident's care. Therefore, its cost cannot be deducted from patient pay.

Electric, motorized, or customized wheelchairs and other equipment are not regularly supplied to residents as part of the cost of care. Requests for deduction of these items' cost from patient pay must be evaluated by DMAS. The nursing home is responsible for monitoring the proper care of the resident's medical supplies and equipment. Failure to do so may cause the nursing home to be responsible for the replacement of such medical supplies or equipment, thus resulting in the denial of the DMAS-122 adjustment.

The provider cannot bill the resident for the difference not paid by other insurance if the provider accepts assignment or contract or is an enrolled provider with DMAS.

Adult day care is not a medical service; therefore, no DMAS-122 can be made. DMAS will not pay to hold a Medicaid recipient's bed when the recipient is admitted to the hospital. Bed-hold days are not considered medically necessary and are not approved when requested on DMAS-122 adjustments.

Even those DMAS-122 forms for recipients without any resources should be reviewed and updated with the same frequency as those with resources. Each resident's DMAS-122 should be reviewed and verified at the time the resident's eligibility is reviewed by the responsible local DSS.

If a nursing home does not receive a DMAS-122 within 30 days from the date of admission or determination of eligibility or a corrected DMAS-122 within 30 days of the request, the nursing home must notify DMAS.

Patient Pay Collection Problems

When the amount collected differs from the patient pay amount appearing on the DMAS-122, the nursing home must make an inquiry with the individual identified as having responsibility to make the payment.

The nursing home must follow its normal collection procedures which will consist of no fewer than three written statements. A copy of the third statement should be sent to the responsible local DSS accompanied by a written notification of the situation, contacts with the responsible party, and the reasons payments have not been made.

The facility must notify the local DSS no later than 120 days from the due date of the payment. Only the above action of the nursing facility will result in consideration of a possible adjustment being made to the DMAS-122.

Upon receipt of the written notice from the nursing facility, the local DSS will take the following action:

- Review the case to determine the accuracy of the current DMAS-122. If the DMAS-122 is incorrect, a corrected form will be provided to the nursing facility.

- If the DMAS-122 is correct, the responsible party must be advised in writing of the need to make the specified payment from the resident's income toward the cost of care, and a copy of the letter will be provided to the administrator of the nursing facility.

- Should review indicate that it is appropriate to change the responsible party, a recommendation for such a change must be made to the source of the benefit payment.

- Should it be determined that the responsible party actually has funds to pay a delinquent amount, he or she must be informed that the payment must be delivered immediately to the nursing facility.

- When the payment not received is a contribution to be made by a legally responsible relative from his or her own income or an expected contribution from such relative, the local DSS must advise that relative of his or her legal responsibility and that failure to comply will result in a non-support petition

being filed with the appropriate court.

- Following the action indicated above and a determination that the funds from this legally responsible relative previously found available are not currently available, a new DMAS-122 for those months in question must be prepared and forwarded to the nursing facility. The nursing facility then has the authority to adjust its billing to Medicaid. It must be noted, however, that funds indicated as available by the responsible local DSS will be considered as being available by Medicaid. The DMAS-122 will not be adjusted if: (1) the amount of patient pay in question is from the resident's own funds which have been withheld by a payee or other individual receiving the resident's funds and have not been paid toward the cost of the resident's care, or (2) the resident directly receives his or her benefits and is considered to be competent but does not meet his or her patient pay responsibility due to the mismanagement of his or her funds.

Nursing Spousal Allowances

The Medicare Catastrophic Coverage Act (MCCA) of 1988 amended § 1924 of Title XIX of the Social Security Act relative to institutionalized individuals and their spouses at home. These provisions of the MCCA became effective September 30, 1989. Prior to actually applying for Medicaid, the institutionalized individual or the community spouse can request a "Resource Assessment" which will be completed by DSS. The Resource Assessment is a compilation of a couple's combined countable resources and a calculation of the amount that is attributable to each spouse.

All nursing facilities are required to advise all new admissions of married residents and their families that Resource Assessments are available upon request. Resource Assessments are available whether or not the institutionalized person is a Medicaid recipient. The Resource Assessment is available only to persons institutionalized for a continuous period that began on or after September 30, 1989. A sample notification form (Notice of Availability of Resource Assessments) can be found in "Exhibits" at the end of this chapter. **A copy of this signed form must be placed in the record of each nursing facility new admission since September 30, 1989.**

The federal government requires DMAS to monitor this process to assure that all new admissions are properly notified. A copy of the signed form in the record will provide sufficient documentation for monitoring purposes.

## RECIPIENTS' RIGHT TO APPEAL AND FAIR HEARING

Any recipient or applicant has the right to appeal whenever Medicaid-covered services are proposed to be terminated, reduced, or suspended. DMAS must notify the individual, in writing, of the right to a hearing and the procedure for requesting a hearing at the time of application and at the time of any action by the agency. For applicants and recipients not familiar with English, a translation of the appeal rights understood by the applicant or recipient must be included.

Whenever DMAS proposes to terminate, reduce, or suspend Medicaid-covered services, it will mail an advance notice of the pending action to the recipient at least 10 days prior to the time of the anticipated action, except as allowed below:

1. Advance notice will be reduced to five (5) days where facts indicate action is necessary because of probable fraud; and

2. Advance notice does not need to be sent if:

    - The recipient has stated in writing that he or she no longer wishes Medicaid services or the information he or she has given requires termination of Medicaid, and the recipient knows that this is the result of giving the information;

    - The recipient has been admitted to an institution where he or she is ineligible for services under the Virginia *State Plan for Medical Assistance*;

    - The recipient moves to another state and has been determined eligible for Medicaid in the new jurisdiction; or

    - The recipient's whereabouts are unknown. The agency will determine that the recipient's whereabouts are unknown if mail sent to the recipient is returned as undeliverable.

DMAS will send a notice reflecting a change in the level of care that an institutionalized recipient receives in the following circumstances:

- The recipient continues to be a resident of the institution;

- The change in level of care was ordered by the recipient's physician; and

- The change in level of care is to a lower level of care covered by Virginia Medicaid.

If all of the preceding conditions are met, notice will be sent on the date of action. If all of the conditions above are not met, then notice will be sent as previously outlined in this section.

**Note:** Money paid for services provided to the recipient will be recovered by DMAS if: 1) the services were provided as a result of required continuation of services in the event that this agency mailed the ten-day or five-day notice as required and the recipient requests a hearing before the date of action, and 2) the recipient's appeal is unsuccessful. The recipient will be informed of this provision at the time a hearing is requested.

## MEDICARE RESIDENT NOTICE OF BILLING RIGHTS

If a Medicare skilled nursing home (SNF) provider believes at the time of admission or

during a resident's stay that Medicare will not pay for skilled nursing or specialized rehabilitative services, the nursing home must inform the resident in writing why the specific services are not covered. The nursing home must use the mandatory denial notice found in the *HCFA Skilled Nursing Facility Manual* in § 358 and keep a copy of this notice on file.

The nursing home is also required to inform each Medicare resident of his or her right to request that the nursing home submit the bill to the Medicare payer, regardless of whether or not the resident believes the service is covered under Medicare. If the resident requests that a bill be submitted for a Medicare decision, even though the nursing home believes the services are not covered under Medicare (a demand bill), then evidence that the submission has occurred should appear in the resident's record.

Failure to give notice using the uniform nursing home denial notice or to submit the bill, if requested by a resident, may constitute a violation of the nursing home's provider agreement to submit information to the intermediary. The required notices are also found in "Exhibits" at the end of this chapter. Letter 1 is used to notify the recipient of non-coverage of services by the intermediary. Letter 4 is used to determine prior to, or upon admission, that the services will not be covered. Letter 5 is used to determine that further services will not be covered. (**Note:** Letters 2 and 3 are no longer used by Utilization Review Committees and were not included.)

# EXHIBITS

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# NOTICE OF AVAILABILITY OF RESOURCE ASSESSMENTS

The Medicare Catastrophic Coverage Act of 1988 changed Medicaid eligibility policies affecting the following individuals:

- Individuals institutionalized on or after September 30, 1989, who have a spouse at home (community spouse),
- Individuals receiving Home and Community-Based Care on or after September 30, 1989, who have a spouse at home (community spouse).

The method of evaluating income and resources for these individuals is affected by these changes. These changes are effective September 30, 1989.

If you become institutionalized or receive Home and Community-Based services on or after September 30, 1989 for a continuous period, have a spouse in the community and you are not already a Medicaid recipient, you may request a Resource Assessment from your local department of social services.

The Resource Assessment compiles your total resources and your spouse's total resources to determine how much would be counted as available to each of you should you apply for Medicaid while you are in the institution.

If you do not agree with the findings of the Resource Assessment, you may file an appeal by writing to the Director of the Division of Client Appeals, Department of Medical Assistance Services, 600 East Broad Street, Suite 1300, Richmond, Virginia 23219.

To request this Resource Assessment, please contact your local department of social services.

I was advised by _____ (name of nursing home or community based care provider) of the availability of the Resource Assessment.

Signed _____

Date _____

FEDERAL BILL OF RIGHTS FOR NURSING FACILITY RESIDENTS
RESIDING IN NURSING FACILITIES THAT PARTICIPATE IN MEDICAID
APRIL 1, 1992

If you are a nursing facility resident, the following are your rights by federal and state laws:

**Exercise of Rights:** You have a right to a dignified existence, self-determination, and communication with an access to persons and services inside and outside the facility. A facility must protect and promote your rights, including each of the following:

- You have the right to exercise your rights as a citizen of the facility and as a citizen of the United States;
- You have the right to be free of interference, coercion, discrimination, or reprisal from the facility in exercising your rights;
- If you are adjudged incompetent under State law by a court of competent jurisdiction, your rights are exercised by the person appointed under State law to act on your behalf; and
- If you have not been adjudged incompetent under State laws by a court of competent jurisdiction, any legal surrogate designated in accordance with State law may exercise your rights to the extent provided by State law.

**Notice of Rights and Services:** The facility must inform you both orally and in writing in a language that you understand of your rights and all rules and regulations governing resident conduct and responsibilities during your stay in the facility. The facility must also provide you with the notice (if any) developed by the State under Section 1919(e)(6) of the Act. Such notification must be made prior to or upon your admission and during your stay. Receipt of such information, and any amendments to it, must be acknowledged in writing.

You or your legal representative have the right, upon an oral or written request, to access all records pertaining to you including current clinical records within 24 hours (excluding weekends and holidays), and, after receipt of your records for inspection, to purchase at a cost not to exceed the community standard photocopies of the records or any portions of them upon request and two working days advance notice to the facility.

You have the right to be fully informed in language that you can understand of your total health status, including but not limited to, your medical condition. You have the right to refuse treatment, and to refuse to participate in experimental research.

The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or when you become eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which you may not be charged as well as those other items and services that the facility offers and for which you may be charged (and the amount of those charges). In addition, the facility must inform you when changes are made to the items and services specified above.

The facility must inform you before, or at the time of admission, and periodically during your stay, of services available in the facility and of the charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate.

The facility must furnish a written description of legal rights which includes 1) a

description of the manner of protecting personal funds; 2) a description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels (this "resource assessment" may be requested from the Virginia Department of Social Services prior to or upon application for Medicaid); 3) a posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid Fraud Control Unit; and 4) a statement that you may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of your property in the facility.

The facility must inform you of the name, specialty, and way of contacting the physician responsible for your care.

The facility must prominently display in the facility written information and provide to you oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.

A facility must immediately inform you, consult with your physician, and if known, notify your legal representative or interested family member when there is 1) an accident involving you which results in injury and has the potential for requiring physician intervention; 2) a significant change in your physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); 3) a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences or to commence a new form of treatment); or 4) a decision to transfer or discharge you from the facility.

The facility must also promptly notify you and, if known, your legal representative or interested family member when there is a change in room or roommate assignment or a change in your rights under federal or State law or regulations.

The facility must record and periodically update the address and phone number of your legal representative or interested family member.

**Protection of Resident Funds:** You have the right to manage your financial affairs, and the facility may not require you to deposit your personal funds with the facility. Upon your written authorization, the facility must hold, safeguard, manage, and account for your personal funds deposited with the facility. The facility must deposit your personal funds in excess of $50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on your funds to that account. In pooled accounts, there must be a separate accounting for each resident's share. The facility must maintain your personal funds that do not exceed $50 in a non-interest bearing account, interest-bearing account, or petty cash fund.

The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of your personal funds entrusted to the facility on your behalf. The system must preclude any commingling of your funds with facility funds or with the funds of any person other than another resident. The individual financial record must be available through quarterly statements and on request to you or your legal representative.

The facility must notify each resident who receives Medicaid benefits 1) when the amount in your account reaches $200 less than the SSI resource limit for one person, and 2) if the amount in the account, in addition to the value of your other nonexempt resources, reaches the SSI resource limit for one person, you may lose eligibility for Medicaid or SSI.

Upon the death of a resident with a personal fund deposited with the facility, the facility must convey within 30 days the resident's funds, and a final accounting of those funds, to the individual or probate jurisdiction administering the resident's estate.

The facility must purchase a surety bond, or otherwise provide assurance satisfactory to the Secretary of Health and Human Services, to assure the security of all personal funds of residents deposited with the facility. The facility may not impose a charge against your personal funds for any item or service for which payment is made under Medicaid or Medicare.

**Free Choice:** You have the right to 1) choose a personal attending physician, 2) be fully informed in advance about care and treatment and of any changes in that care or treatment that may affect your well-being, and 3) unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, participate in planning care and treatment or changes in care and treatment.

**Privacy and Confidentiality:** You have the right to personal privacy and confidentiality of your personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups. This does not require a facility to provide a private room for each resident.

You may approve or refuse the release of personal or clinical records to any individual outside the facility, except when you are transferred to another health care institution or record release is required by law.

**Grievances:** You have the right to voice grievances without discrimination or reprisal. Such grievances include those with respect to treatment which has been furnished as well as that which has not been furnished. You have the right to prompt efforts by the facility to resolve grievances you may have, including those with respect to the behavior of other residents.

**Examination of survey results:** You have the right to 1) examine the results of the most recent survey conducted by federal or State surveyors and any plan of correction in effect with respect to the facility. The facility must make the survey results available to you in a place readily accessible and must post a notice of their availability. You also have the right to receive information from agencies acting as client advocates and be afforded the opportunity to contact those agencies.

**Work:** You have the right to 1) refuse to perform services for the facility or 2) perform services for the facility, if you choose, when the facility has documented the need or desire for work in the plan of care. The plan must specify the nature of the services performed and whether the services are voluntary or paid. Compensation for paid services must be at or above prevailing rates, and you must agree to the work arrangement described in the plan of care.

**Mail:** You have the right to privacy in written communications, including the right to send and promptly receive mail that is unopened and have access to stationery, postage, and writing implements at your own expense.

**Access and Visitation Rights:** You have the right and a nursing facility must provide immediate access to you by the following:

- Any representative of the U.S. Department of Health and Human Services, any representative of the State, your individual physician, the State Long-Term Care Ombudsman, the agency responsible for the protection and advocacy system for developmentally disabled individuals, and the agency responsible for the protection and advocacy system for mentally ill individuals;

- Subject to your right to deny or withdraw consent at any time, by your immediate family or other relatives; and

- Subject to reasonable restrictions and your right to deny or withdraw consent at any time, by others who are visiting with your consent.

The facility must also provide reasonable access to you by any entity or individual that provides health, social, legal, or other services to the resident, subject to your right to deny or withdraw consent at any time. The facility must allow representatives of the State ombudsman to examine your clinical records, with your permission (or your legal representative) and consistent with State law.

**Telephone:** You have the right to have reasonable access to the private use of a telephone where calls can be made without being overheard.

**Personal Property:** You have the right to retain and use personal possessions, including some furnishings, and appropriate clothing, as space permits, unless to do so would infringe upon the rights and health and safety of other residents.

**Married Couples:** You have the right to share a room with your spouse when married residents live in the same facility and both spouses consent to the arrangement.

**Self-administration of Drugs:** An individual resident may self-administer drugs if the interdisciplinary team has determined that this practice is safe.

**Refusal of Certain Transfers:** You have the right to refuse a transfer to another room within the institution if the purpose of the transfer is to relocate you from the distinct part of the institution that is a skilled nursing facility (SNF) to a part of the institution that is not a SNF, or, if you are a resident of a nursing facility from the distinct part of the institution that is a nursing facility to a distinct part of the institution that is a SNF. Exercising this right to refuse transfer does not affect your eligibility or entitlement to Medicaid benefits.

**Transfer and discharge:** Transfer and discharge includes the movement of a resident to a bed outside of the certified facility whether that bed is in the same physical plant or not. Transfer and discharge does not refer to the movement of a resident to a bed within the same certified facility. The facility must permit you to remain in the facility and not transfer or discharge unless:

a. The transfer or discharge is necessary for your welfare, and your needs cannot be met in the facility;

b. The transfer or discharge is appropriate because your health has improved sufficiently so you no longer need the services provided by the facility;

c. The safety of individuals in the facility is endangered;

d. The health of individuals in the facility would otherwise be endangered;

e. You have failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. If you become eligible for Medicaid after admission to a facility, the facility may charge you only allowable charges under Medicaid; or

f. The facility ceases to operate.

When the facility transfers or discharges you under any of the circumstances described in (a) through (e) above, your clinical record must be documented. The documentation must be made by your physician when transfer or discharge is necessary because of the reasons

described in (a) or (b), and by a physician when transfer or discharge is necessary due to the reason stated in (d).

Before a facility transfers or discharges you, the facility must 1) notify you and, if known, a family member or your legal representative of the transfer or discharge and the reasons for the move in writing and in a language and manner you understand; 2) record the reasons in your clinical record; and 3) include in the notice the items described in (a) through (f) above. The notification must be made by the facility at least 30 days before you are transferred or discharged. Notice may be made as soon as is practicable before discharge or transfer when:

- The safety of the individuals in the facility would be endangered;
- The health of individuals in the facility would be endangered;
- Your health improves sufficiently to allow a more immediate transfer or discharge;
- An immediate transfer or discharge is required by your urgent medical needs; or
- You have not resided in the facility for 30 days.

The written notice must include a) the reason for the transfer or discharge, b) the effective date of transfer or discharge, c) the location to which you are transferred or discharged; and d) a statement that you have the right to appeal the action to the State. The notice must also include the name, address, and telephone number of the State Long-Term Care ombudsman. If you have a developmental disability or mental illness, the notice must include the mailing address and telephone number of the Department of Rights of Virginians with Disabilities.

A facility must provide sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility.

In addition to the federal requirements above regarding transfer and discharge, you should also be aware of the requirements of § 32.1-138 of the Code of Virginia:

- All established policies and procedures regarding the rights and responsibilities of residents shall be printed in at least 12-point type and posted conspicuously in a public place in all nursing facilities licensed under the provisions of §32.1-123 et seq. of the Code of Virginia. The notice must include the name and telephone number of the complaint coordinator in the Division of Licensure and Certification of the Virginia Department of Health as well as the toll-free number for the Virginia Long-Term Care Ombudsman Program and any substate ombudsman program serving the area. Copies of such policies and procedures shall be given to residents upon admittance to the facility and made available to residents currently in residence, to any guardians, next of kin, sponsoring agency or agencies, and to the public.

  Per §32.1-138.1. of the Code, a nursing facility may discharge or transfer a resident, including transfer within the facility, only:

  1. If appropriate to meet that resident's documented medical needs;
  2. If appropriate to safeguard that resident or one or more other residents from physical or emotional injury; or
  3. In the event of nonpayment for his or her stay except as prohibited by Titles XVIII or XIX of the Social Security Act and the Virginia State Plan

for Medical Assistance Services.

Except in an emergency involving the resident's health or well-being, no resident shall be transferred, including transfer within the facility, or discharged without prior consultation with the resident, the resident's family or responsible party, and the resident's attending physician. If the attending physician is unavailable, the facility's medical director, in conjunction with the nursing director, social worker, or another health professional, must be consulted. Reasonable advance written notice must be given in the following manner. For a voluntary transfer or discharge, notice must be reasonable under the circumstances. For an involuntary transfer, including a transfer within the facility, reasonable advance notice must be given to the resident at least five days prior to the transfer.

In the case of an involuntary transfer or discharge, the attending physician of the resident or the medical director of the facility shall make a written notation in the resident's record approving the transfer or discharge after consideration of the effects of the transfer (including a transfer within the facility) or discharge, appropriate actions to minimize the effects of the transfer or discharge, and the care and kind of service the resident needs upon transfer or discharge.

**Notice of Bed-Hold Policy and Readmission:** Before a nursing facility transfers you to a hospital or allows you to go on therapeutic leave, the nursing facility must provide written information to you and a family member or legal representative that specifies 1) the duration of the bed-hold policy under the State plan if any, during which you are permitted to return and resume residence in the facility; and 2) the facility's policies regarding bed-hold periods following hospitalization or therapeutic leave, permitting you to return.

At the time of your transfer for hospitalization or therapeutic leave, a nursing facility must provide to you and a family member or legal representative written notice which specifies the duration of the bed-hold policy. A nursing facility must establish and follow a written policy under which you, whose hospitalization or therapeutic leave exceeds the bed-hold period under the State plan, are readmitted to the facility immediately upon the first availability of a bed in a semi-private room if you 1) require the services provided by the facility and 2) are eligible for Medicaid nursing facility services.

Medicaid pays for the nursing facility to hold your bed for up to 18 overnight stays a year for therapeutic leave including visits with family or friends or admission to a rehabilitation facility for an evaluation.

**Equal Access to Quality Care:** A nursing facility must establish and maintain identical policies and practices regarding the transfer, discharge, and provision of services under the State plan for all individuals regardless of the source of payment. The facility may charge any amount for services furnished to non-Medicaid residents consistent with the required notice describing the charges. The State is not required to offer additional services on behalf of a resident other than services provided in the State plan.

**Admissions Policy:** The facility must not require residents or potential residents to waive their rights to Medicare or Medicaid and not require oral or written assurance that residents or potential residents are not eligible for, or will not apply for, Medicare or Medicaid benefits.

The facility must not require a third-party guarantee of payment to the facility as a condition of admission, expedited admission, or continued stay in the facility. However, the facility may require an individual who has legal access to your income or resources available to pay for facility care to sign a contract, without incurring personal financial liability, to provide facility payment from your income or resources.

If you are eligible for Medicaid, a nursing facility must not charge, solicit, accept, or

receive, in addition to any amount otherwise required to be paid under the State plan, any gift, money, donation, or other consideration as a precondition of admission, expedited admission, or continued stay in the facility. However, a nursing facility may charge a resident who is eligible for Medicaid for items and services you have requested and received, and that are not specified in the State plan as included in the term "nursing facility services" so long as the facility gives proper notice of the availability and cost of these services to you and does not condition your admission or continued stay on the request for and receipt of such additional services.

A nursing facility may solicit, accept, or receive a charitable, religious, or philanthropic contribution from an organization or from a person unrelated to a Medicaid-eligible resident or potential resident, but only to the extent that the contribution is not a condition of admission, expedited admission, or continued stay in the facility for a Medicaid-eligible resident.

**Restraints:** You have the right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience and not required to treat your medical symptoms.

**Abuse and Staff Treatment of Residents:** You have the right to be free from verbal, sexual, physical or mental abuse, corporal punishment, and involuntary seclusion. The facility must develop and implement written policies and procedures that prohibit the mistreatment, neglect, or abuse of residents and the misappropriation of resident property. The facility must not use verbal, mental, sexual, or physical abuse; corporal punishment; or involuntary seclusion. The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law or have had a finding entered into the State nurse aide registry concerning the abuse, neglect, mistreatment of residents or the misappropriation of their property.

The facility must also report any knowledge it has of actions by a court of law against an employee which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source, and misappropriation of resident property are reported immediately to the administrator of the facility or to other officials in accordance with State law through established procedures (including to the Department of Health, Division of Licensure and Certification).

In addition, the facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his or her designated representative and to other officials in accordance with State law (including to the Department of Health, Division of Licensure and Certification) within five (5) working days of the incident. If the alleged violation is verified, appropriate corrective action must be taken.

**Dignity:** A facility must care for you in a manner and in an environment that promotes maintenance or enhancement of your quality of life. The facility must promote care for you in a manner and in an environment that maintains or enhances your dignity and respect in full recognition of your individuality.

**Self-Determination and Participation:** You have the right to 1) choose activities, schedules, and health care consistent with your interests, assessments, and plans of care, 2) interact with members of the community both inside and outside the facility, and 3) make choices about aspects of your life in the facility that are significant to you.

**Participation in resident and family groups:** you have the right to organize and participate in resident groups in the facility. Your family has the right to meet in the facility with the families of other residents in the facility. The facility must provide a

resident or family group, if one exists, with private space. Staff or visitors may attend meetings at the group's invitation. The facility must provide a designated staff person responsibility for providing assistance and responding to written requests that result from group meetings. When such a resident or family group exists, the facility must listen to the views and act upon the grievances and recommendations of residents and families concerning proposed policy and operational decisions affecting resident care and life in the facility.

**Activities:** the facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident.

**Social Services:** The facility must provide medically related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.

**Accommodation of Needs:** You have the right to reside and receive services in the facility with reasonable accommodation of individual needs and preferences, except when your health or safety or that of other resident's would be endangered, and receive notice before your room or roommate in the facility is changed.

**Environment:** The facility must provide a safe, clean, comfortable, and homelike environment, allowing you to use your personal belongings to the extent possible. The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; clean bed and bath linens that are in good condition; private closet space in each resident room; adequate and comfortable lighting levels in all areas; comfortable and safe temperature levels; and maintenance of comfortable sound levels.

State Long Term Care Ombudsman

Department for the Aging
Long-Term Care Ombudsman
700 East Franklin Street
Tenth Floor
Richmond, Virginia 23219
Telephone Toll Free 1-800-552-3402

State Agency for Developmentally Delayed or Mentally Ill

Department For Rights of Virginians With Disabilities
101 N. 14th Street
Richmond, Virginia 23219
Telephone Toll Free 1-800-552-3962-Voice or TDD (Telecommunication Devices for the Deaf)

State Survey Agency

Department of Health
Division of Licensure and Certification
3600 Centre, Suite 216
3600 West Broad Street
Richmond, Virginia 23230
Telephone 804-367-2102

State Medicaid Agency

Department of Medical Assistance Services
Long Term Care Division
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

State Mental Health/Mental Retardation Agency

Department of Mental Health, Mental Retardation and Substance Abuse Services
P. O. Box 1797
Richmond, Virginia 23214
Telephone 804-786-3921

SNF DENIAL LETTER ONE
INTERMEDIARY DETERMINATION OF NONCOVERAGE

Name of SNF
Address
Date

TO: Name
Address

RE: Name of Beneficiary
HICN
Date of Admission

On (Date), the Medicare intermediary advised us that the services you receive will no longer qualify as covered under Medicare beginning (Date).

The Medicare intermediary will send you a formal determination as to the noncoverage of your stay after (Date). If you wish to appeal, the formal notice will contain information about how this can be done. The intermediary will inform you of the reason for denial and your appeal rights.

We regret that this may be your first notice of the noncoverage of services under Medicare. Our efforts to contact you earlier, in person or by telephone, were unsuccessful.

Please verify receipt of this notice by signing below.

Sincerely,

_____
Signature of Administrative Officer

SNF DENIAL LETTER ONE
VERIFICATION OF RECEIPT OF NOTICE

A. This acknowledges that I received this attached notice of noncoverage of services under Medicare on (date of receipt).

_____
(Signature of Beneficiary or Person acting on Beneficiary's behalf)

B. This is to confirm that you were advised of the noncoverage of the services under Medicare by telephone on (date of telephone contact).

_____
(Name of Beneficiary or Representative contacted)

_____
(Signature of Administrative Officer)

KEEP A COPY OF THIS FOR YOUR RECORDS

SNF DENIAL LETTER FOUR
SNF DETERMINATION ON ADMISSION

Name of SNF
Address
Date

TO: Name
Address

RE: Name of Beneficiary
HICN
Date of Admission

On (Date), we reviewed your medical information available at the time of, or prior to your admission, and we believe that the services (you or beneficiary's name) needed did not meet the requirements for coverage under Medicare. The reason is:

(Insert specific reason services are determined to be noncovered.)

This decision has not been made by Medicare. It represents our judgment that the services you needed did not meet Medicare payment requirements. Normally, under this situation, a bill is not submitted to Medicare. A bill will only be submitted to Medicare if you request that a bill be submitted. Furthermore, if you want to appeal this decision, you must request that a bill be submitted. If you request that a bill be submitted, the Medicare intermediary will notify you of its determination. If you disagree with that determination, you may file an appeal.

Under a provision of the Medicare law, you do not have to pay for noncovered services determined to be custodial care or not reasonable or necessary unless you had reason to know the services were noncovered. You are considered to know that these services were noncovered effective with the date of this notice.

If you have questions concerning your liability for payment for services you received prior to the date of this notice, you must request that a bill be submitted to Medicare.

We regret that this may be your first notice of the noncoverage of services under Medicare. Our efforts to contact you earlier in person or by telephone were unsuccessful.

Please check one of the boxes below to indicate whether or not you want your bill submitted to Medicare and sign the notice to verify receipt.

Sincerely yours,

_____
Signature of Administrative Officer

SNF DENIAL LETTER FOUR
REQUEST FOR MEDICARE INTERMEDIARY REVIEW

___ A. I **do** want my bill submitted to the intermediary for a Medicare decision. You will be informed when the bill is submitted.

If you do not receive a formal Notice of Medicare Determination within 90 days of this request you should contact: (Name and address of intermediary).

___ B. I **do not** want my bill submitted to the intermediary for a Medicare decision.

I understand that I do not have Medicare appeal rights if no bill is submitted.

NOTE: Beginning on October 1, 1989, you are not required to pay for services which could be covered by Medicare until a Medicare decision has been made.

VERIFICATION OF RECEIPT OF NOTICE

C. This acknowledges that I received this notice of noncoverage of services under Medicare on (date of receipt).

_____
(Signature of Beneficiary or Person acting on Beneficiary's behalf)

D. This is to confirm that you were advised of the noncoverage of the services under Medicare by telephone on (date of telephone contact).

_____
(Name of Beneficiary or Representative contacted)

_____
(Signature of Administrative Officer)

KEEP A COPY OF THIS FOR YOUR RECORDS

SNF DENIAL LETTER FIVE
SNF DETERMINATION ON CONTINUED STAY

Name of SNF
Address
Date

TO: Name
Address

RE: Name of Beneficiary
HICN
Date of Admission

On (Date), we reviewed your medical information and found that the services furnished (you or beneficiary's name) no longer qualified as covered under Medicare beginning (Date).

The reason is: (Insert specific reason services are considered noncovered.)

This decision has not been made by Medicare. It represents our judgment that the services you needed no longer met Medicare payment requirements. A bill will be sent to Medicare for the services you received before (Date). Normally, the bill submitted to Medicare does not include services provided after this date. If you want to appeal this decision, you must request that the bill submitted to Medicare include the services we determined to be noncovered. If you disagree with that determination, you may file an appeal.

Under a provision of the Medicare law, you do not have to pay for noncovered services determined to be custodial care or not reasonable or necessary unless you had reason to know the services were noncovered. You are considered to know that these services were noncovered effective with the date of this notice.

We regret that this may be your first notice of the noncoverage of services under Medicare. Our efforts to contact you earlier in person or by telephone were unsuccessful.

Please check one of the boxes below to indicate whether or not you want your bill submitted to Medicare and sign the notice to verify receipt.

Sincerely yours,

_____
Signature of Administrative Officer

SNF DENIAL LETTER FIVE
REQUEST FOR MEDICARE INTERMEDIARY REVIEW

___ A. I **do** want my bill for services I continue to receive to be submitted to the intermediary for a Medicare decision. You will be informed when the bill is submitted.

If you do not receive a formal Notice of Medicare Determination within 90 days of this request you should contact: (Name and address of intermediary).

___ B. I **do not** want my bill for services I continue to need to be submitted to the intermediary for a Medicare decision.

I understand that I do not have Medicare appeal rights if no bill is submitted.

NOTE: Beginning on October 1, 1989, you are not required to pay for services which could be covered by Medicare until a Medicare decision has been made.

VERIFICATION OF RECEIPT OF NOTICE

C. This acknowledges that I received this notice of noncoverage of services under Medicare on (date of receipt).

_____
(Signature of Beneficiary or Person Acting on Beneficiary's Behalf)

D. This is to confirm that you were advised of the noncoverage of the services under Medicare by telephone on (date of telephone contact).

_____
(Name of Beneficiary or Representative contacted)

_____
(Signature of Administrative Officer)

KEEP A COPY OF THIS FOR YOUR RECORDS